



CALIFORNIA DEPARTMENT OF  
**Mental Health**

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**IMPACT OF MEDICAL STAFF MEMBERSHIP  
AND PRIVILEGES FOR CLINICAL  
PSYCHOLOGISTS ON QUALITY OF CARE, AND  
ON COST-EFFECTIVENESS ISSUES**

**A Report to the Legislature  
In Response to  
Chapter 717, Statutes of 1998**

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## **Executive Summary**

AB 947, Chapter 717, Statutes of 1998, added Section 1316.5 to the Health and Safety Code requiring the establishment of rules and medical staff bylaws that include provisions for medical staff membership and clinical privileges for clinical psychologists within the scope of their licensure. The statute also requires a report to the legislature on the impact of medical staff membership and privileges for clinical psychologists on quality of care, and on cost-effectiveness issues.

Since that time, all bylaws of the Department of Mental Health (DMH) state hospitals have been amended accordingly. Currently, most psychologists are members of the medical staff at each hospital. In addition, psychologists may apply for all established clinical privileges that are within the scope of their license and for which they meet the education, experience and current competency criteria established for each of the requested privileges. Psychologists now also have greater representation on medical staff committees with the goal of representation proportionate to the number of psychologists in the overall medical staff.

The Department of Health Services (DHS) is working to clarify regulations that define the psychologist's role within the scope of their licensure. Within the next year DHS anticipates submitting regulatory changes to broaden the scope of responsibility for psychologists. Additionally, the ongoing development and implementation of the Recovery Treatment Model will expand the utilization of psychologists by making them key members of the core treatment team and give them new responsibilities. As key members of the core treatment team, psychologists will have input into all aspects of a patient's care and will perform in equal partnership with other team members. They will also play a key role in the assessment process, which will include a Positive Behavior Support Plan (PBS) that promotes and encourages individualized wellness and recovery.

The Bureau of State Audits (BSA) investigated the implementation of AB 947 and issued a report in July 2004. Issues or concerns identified in that report which have yet to be resolved include psychologists acting in positions of clinical leadership, such as attending/co-attending. Discussions addressing this issue are ongoing at the state facilities. Additionally, representation on medical staff committees is an identified area of focus.

The clarification of regulations, the proportionate representation on medical staff committees, and the implementation of the Recovery Treatment Model, including the Positive Behavior Support Plan, will all increase the utilization of psychologists. It will place psychologists in key roles on the treatment teams and will have a positive effect on the quality of care in state owned and operated facilities.

Greater utilization of psychologists and implementation of the Recovery Treatment Model allow the health care disciplines to work more effectively together. This partnership makes better use of clinical resources while improving quality of care. DMH believes that the impact of medical staff membership and privileges for clinical psychologists has been improved quality of care at no additional cost.

## Background

**Historical Context.** In 1973, the Legislature added Section 1316 of the Health and Safety Code to prohibit discrimination against dentists in relation to their membership on a hospital's medical staff and their clinical practice in hospital settings. Assembly Bill (AB) 3141, authored by Assembly Member Gallegos, added Section 1316.5 to the Health and Safety Code to provide the same types of anti-discrimination protection for psychologists that had previously been afforded dentists and podiatrists. Dissatisfaction with the implementation of AB 3141 resulted in the passage of a second bill (AB 947), also authored by Assembly Member Gallegos. Section 1316.5 of the Health and Safety Code, as amended, requires state owned and operated facilities to establish rules and medical staff bylaws that do not discriminate against applicants for medical staff membership solely on the basis of the practitioner's degree, e.g., M.D., D.O., DDS, DPM or a doctoral degree in psychology. This statute further requires the DMH to report to the legislature on the impact of medical staff membership and privileges for clinical psychologists on quality of care and on cost effectiveness issues. This report complies with this requirement.

Each state hospital places each of its patients under the care of an interdisciplinary treatment team that is responsible for multiple patients with similar needs. A physician, usually a psychiatrist, serves as the attending clinician or the primary provider of care, for the treatment team. Attending clinicians' duties include making the official diagnosis of record for patients and approving patient treatment plans. Other treatment team members, including psychologists, help develop and implement treatment plans. Specifically, they provide services such as psychological evaluations, psychotherapy, and various psychological assessments. Because the vast majority of state hospital patients use significant numbers of medications and have co-occurring medical conditions, both of which require a medical license for treatment, there are few opportunities for a psychologist to serve as the attending clinician in these facilities.

In the case, *California Association of Psychologists (CAPP) v Rank*, the California Supreme Court ruled in 1990 that under state law an acute psychiatric hospital that admits psychologists to its staff may permit the psychologists to take primary responsibility for the diagnosis and treatment of patients.

**Actions taken by the Department of Health Services (DHS).** In response to the *CAPP v Rank* decision, the DHS has continued efforts to reduce the barriers for psychologists who are members of the medical staff, and forbids discrimination with regard to the provision of services which are within the scope of professional licensure. In the Spring of 2005, the DHS amended the following Title 22 regulations to clarify the role of clinical psychologists in acute psychiatric hospital and general acute care hospital settings:

- Section 71203(A): (Section 70577(e) (1) for general acute hospital settings) Psychiatrists or clinical psychologists within the scope of their licensure and subject to the rules of the facility shall be responsible for the diagnostic

formulation for their patients and the development and implementation of each patient's treatment plan.

- Section 71517: (Section 70717 for general acute hospital settings) states that a hospital that admits clinical psychologists to its staff may permit such psychologists to take primary responsibility for the admission, diagnosis, treatment, and discharge of their patients.
- Section 71545: Patients shall be placed in restraint only on the written order of the physician or clinical psychologist, acting within the scope of his or her professional licensure.

These provisions do not extend to Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) facilities, including distinct parts in acute psychiatric hospitals. In state hospitals, ICF and SNF patients represent approximately 70 percent of total patient census.

**Bureau of State Audits (BSA) Review.** At the request of the Legislature, BSA investigated the implementation of AB 947. It issued its report, "Department of Mental Health: State and Federal Regulations Have Hampered Its Implementation of Legislation Meant to Strengthen the Status of Psychologists at Its Hospitals, and Psychologists Are Not Adequately Represented on Key Hospital Committees", dated July 6, 2004.

The report concluded that even though the DMH acted to implement AB 947 at its four hospitals, a key issue – whether psychologists have the authority to serve as attending clinicians in patient care and treatment – remained unresolved. The report noted the difficulty in implementing AB 947. The BSA's report made two recommendations.

#### Recommendation #1

"The Department should work to resolve the continuing issue regarding whether psychologists can serve as attending clinicians in its four hospitals. This effort should include providing leadership and guidance to the administrators, psychiatrists, and psychologists at each hospital to find reasonable solutions to satisfy the statutory and regulatory requirements governing patient care."

In its response to the BSA report, DMH noted that the Department of Health Services (DHS) continues to draft regulation amendments for Intermediate Care Facilities (ICF) and Skilled Nursing Facilities (SNF) to reduce barriers and allow psychologists to more fully practice the scope of their license as the primary provider of care in state hospitals. Regulation revisions for acute care facilities have been completed. The reduction of these regulatory barriers will facilitate DMH's efforts to allow psychologists to more fully participate in the treatment of patients as attending / co-attending clinicians.

## Recommendation #2

“To ensure the appropriate level of representation for psychologists on the committees at the department’s hospitals, the department should direct the hospitals to annually review the composition of their medical staffs and the proportion of psychologists, psychiatrists, and other medical staff on their medical executive, credentials and if applicable, bylaws committees. Each hospital should modify, to the extent possible, the membership of these committees to more closely reflect the composition of its medical staff.”

In its response to the BSA report, DMH responded that it had issued Special Order 009 – *Medical Staff Committee Composition*, dated September 1, 2004. This Special Order required hospitals to annually review the composition of their medical staffs and the proportion of various disciplines and license types, and to the extent possible modify the membership of the Medical Executive, Credentials, and Bylaws Committees to more closely reflect the composition of its overall medical staff, understanding that the Medical Executive Committee membership is determined by election, not appointment.

## **Actions Taken by DMH / Results**

The DMH has taken vigorous steps to implement both the spirit and the letter of Section 1316.5. The following actions (discussed in more depth later) have been taken.

- a. The medical staff bylaws of each DMH state owned and operated hospital were amended to incorporate psychologists into the membership of the medical staff with full participation on medical staff committees by December 18, 1997, before the effective date of AB 947. Psychologists may apply for all established clinical privileges that are within the scope of their license and for which they meet the education requirements, experience, and current competency criteria established for each of the requested privileges.
- b. Enhancements are now underway at the state hospitals that reflect a fundamental shift in DMH's treatment philosophy to one focusing on recovery rather than focusing solely on the disease, disability, or disorder presented. In a recovery oriented treatment system, the treatment team must focus on the functional skills desired and necessary to live successfully after discharge from the hospital; provide treatment, rehabilitation, and supports to develop those skills; as well as address the psychiatric and psychological problems presented. Successful implementation of the Recovery Treatment Model requires that all members of the interdisciplinary treatment team work together as a single unit, using the individual talents and training of each member in all aspects of treatment. In the Recovery Treatment Model, the role and responsibilities of the psychologist is enhanced because of their particular skills and training in the areas of assessment and behavioral interventions.
- c. Several special orders have been issued to clarify and expand the role of psychologists. Special Orders 008, *Clinical Psychologist Functions*, and 009, *Medical Staff Committee Composition*, (attached) further define the duties and responsibilities psychologists may perform within the scope of their license and for which they have demonstrated competence. Special Order 129, *Positive Behavior Support*, (attached) outlines the policies and procedures regarding the Positive Behavioral Support program of which the psychologists have a key role. The Positive Behavioral Support Team is under the direct supervision of the team psychologist, who makes team assignments.

**Medical Staff Membership and Clinical Privileges.** Membership on the medical staff is a privilege which is extended only to those professionally competent practitioners who continuously meet the qualifications, standards and requirements that are set forth in the facilities' bylaws. They must offer evidence of training and/or experience, current competence, professional ethics and health status as it relates to the ability to perform staff duties. Membership includes those licensed clinicians permitted by law and the

hospital to provide patient care services without direction or supervision within the scope of their licenses and in accordance with individually granted clinical privileges.

The following table shows a breakdown of psychologists employed at the state hospitals with regard to medical staff membership. Membership is encouraged for all psychologists meeting minimum criteria: 1) must be licensed, and 2) must have up to 3 years clinical experience post licensure. The amount of clinical experience needed post licensure is a local decision that is determined by each state hospital medical staff.

## Psychologist Representation on Medical Staff

Hospitals	Total on Staff	Total on Medical Staff	Percentage on Medical Staff	Total Not on Medical Staff	Reasons (for non-membership)
ASH	43	33	77%	10	7 Pre-Licensed 2 Licensed * 1 Associate **
CSH	14	6	46%	8	8 Pre-Licensed
MSH	39	30	80%	9	9 Pre-Licensed
NSH	51	35	69%	16	11 Pre-Licensed 5 Licensed *
PSH	48	37	77%	11	9 Pre-Licensed 2 Licensed *
	195	141	72%	54	

\* A psychologist has a license, but not yet enough clinical experience for membership or has not yet applied for membership.

\*\* An Associate member of the medical staff is a full non-voting member of the medical staff, permanently employed by DMH, and working less than half time.

Having clinical privileges is a two-step process. The Medical Staff first creates the privilege or credential. Then, medical staff members apply for the privilege, which is awarded only after there has been an assessment of the professional's current competency to practice the privilege.

The DMH process for establishing, approving, and granting clinical privileges to all practitioners requires each department within the medical staff to request privileges for its members based on the needs of the individuals served and on the needs, the policies, and the capabilities of the hospital. When a need for a privilege has been



determined, the department defines the privilege in a way that practitioner activities can be measured and the quality of the activity can be compared to the privilege standard. This assures that proctorship and peer review processes are conducted in an objective and measurable fashion. The department also addresses how the privilege will be practiced, differentiated, shared, etc., when more than one department offers the same privilege.

Once the department has identified and defined the privilege, the department establishes qualifying criteria specific to the privilege. The criteria consist of measurable standards of current competency, education, experience, license and any other standard that is applicable to the practice of the privilege.

Each department proposes privileges, along with qualifying criteria, to the medical staff through the Medical Executive Committee (MEC) for initial approval by the medical staff and submission to the Governing Body for final approval. The MEC works collaboratively with departments to establish privileges that are reasonable and necessary for the care and treatment of individuals served in state hospitals.

If the Governing Body approves the establishment of a privilege and the qualifying criteria for the privilege, then practitioners who can show proof of meeting the criteria may apply to the medical staff for the privilege. Final approval of the Governing Body is required to grant that privilege to a qualifying practitioner.

**Special Order 008 (SO 008).** SO 008, *Clinical Psychologist Functions*, defines the activities and line of authority of psychologists in the state hospital setting. The special order identifies core functions that are administrative assignments designed to aid in the delivery of individual care in state hospitals. Clinical psychologists may perform these core functions when the activities are part of the individual's approved treatment plan or the physician responsible for the individual's overall care delegates the functions. Some of these assignments may require the psychologist to have been granted the appropriate clinical privileges in order to perform the function.

Medical staff status for psychologists includes, and provides for, the right to pursue and practice full clinical privileges for the holders of a doctoral degree of psychology within the scope of their licensure. These rights and privileges are limited or restricted only upon the basis of an individual practitioner's demonstrated competence. Competency is determined by health facility rules and medical staff bylaws that are applied in good faith, equally and in a nondiscriminatory manner, to all practitioners, regardless of whether they hold an M.D., D.O., D.D.S., D.P.M. or doctoral degree in psychology.

**The Recovery Treatment Model.** State hospitals are implementing a recovery model of treatment. This philosophy views the role of treatment as supporting each individual's goals toward recovery, rehabilitation and habilitation, and enabling individuals to grow and develop in ways benefiting their mental health, health and well being. Each individual served is encouraged to participate in identifying his or her needs and goals, and in selecting treatment options. State hospitals then design

therapeutic services to address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals. An interdisciplinary team must consistently make treatment plans to meet the individual's specific recovery and wellness goals. The team consists of a stable core including the individual served, the psychiatrist, psychologist, rehabilitation therapist, registered nurse, social worker, and psychiatric technician.

Each treatment plan focuses on an individual's behavior with a view towards having the individual learn to control his/her mental illness. The Recovery Treatment Model does not "cure" mental illness as much as it teaches individuals to deal with their mental illness through behavior modification so that the individual can live and thrive in the community. Each mentally ill person has strengths as well as weaknesses. The interdisciplinary team seeks to develop and prioritize measurable behavioral goals that are based on these strengths. Psychologists excel in this area and their input becomes particularly important. Under the Recovery Treatment Model, psychologists are expected to take stronger leadership roles in treating mentally ill individuals.

Assessments of an individual's symptoms, neurological/cognitive impairments, and other relevant information are critical to constructing an effective treatment plan. Assessments must include a Positive Behavior Support plan (PBS) which is an overall strategy to promote and encourage wellness and recovery that is individualized, relies on positive incentives and encouragement rather than aversive conditioning or punishments. The plan spells out detailed standards for assessments that must be completed on each individual by verifiably competent staff across a number of disciplines. Psychologists are the team leaders for the PBS teams. In addition, because of their particular expertise and training, psychologists are taking the lead in developing a number of new psychological assessments needed in state hospitals.

It is important to note that this marks the first time psychologists have been utilized in this manner. The implementation of the Recovery Treatment Model places psychologists and neuropsychologists in key leadership roles on the PBS team and the Behavioral Consultation Committee (BCC), charging them with the development and implementation of institutional policies and practices related to positive behavioral interventions and as consultants to core treatment teams. Their particular leadership, assessment, and planning talents are being brought to bear on patients with particularly difficult behavioral issues.

From a cost effectiveness standpoint, the implementation of the Recovery Treatment Model better utilizes the skills and training of the psychology staff of the state hospitals. However, it does not mean that the need for psychiatrists is in any way reduced because of the severity of the mental illnesses state hospital patients present. It has also not resolved the disagreements that exist between the two disciplines with regard to their respective roles as leaders of the treatment teams.

**Special Order 129 (SO 129).** SO 129 – *Positive Behavioral Support*, outlines and defines the policies and procedures regarding the Positive Behavioral Support (PBS) program for all DMH state hospitals, and requires that each hospital incorporate this policy into their Positive Behavioral Support Administrative Directive without interpretation.

PBS is embedded in the overall Wellness and Recovery Plan (WRP) and is a process of collaborative assessment, intervention planning, and implementation of interventions by the individual, the individual's Wellness core treatment team, other caregivers and professional staff, consultants, and family members. PBS plans are designed to support individuals in developing and maintaining recovery-enhancing behaviors and life styles. As positive functionally equivalent "replacement behaviors" develop, maladaptive behaviors are rendered irrelevant, inefficient and unnecessary. PBS is a data-based approach to behavior change that employs empirical evaluation of intervention outcomes.

The Positive Behavior Support Team consists of a clinical psychologist, registered nurse, two psychiatric technicians, and a data person. The PBS team is appointed and supervised by the Chief of Psychology in consultation with the Medical Director and Clinical Administrator. The accountability of the team rests with the Chief of Psychology, and each team functions as a unit under the direct supervision of the psychologist of the team who makes all clinical assignments within the team.

Clinical psychologists are key to every aspect of the Positive Behavioral Support Program. They provide direction on the PBS teams and to the core treatment team. They are involved with the assessment, planning, implementation, and training of staff. They also provide consultation and follow-up to ensure clinical effectiveness of PBS interventions, and based on outcome data, assist the PBS team in a plan revision if necessary.

**Special Order 009 (SO 009).** SO 009 – *Medical Staff Committee Composition*, requires hospitals to annually review the composition of their medical staffs and the proportion of various disciplines and license types, and to the extent possible modify the membership of the Medical Executive, Credentials, and Bylaws Committees to more closely reflect the composition of its overall medical staff.

The Medical Executive Committee (MEC) in each hospital is composed of a combination of elected and standing members. A member-at-large can be either appointed by the Chief of Staff (at Atascadero State Hospital) or elected (at Napa, Metropolitan, and Patton State Hospitals) as needed to establish a representation of the overall medical staff membership.

The Chiefs of Staff appoint the Credentials Committee members at all four of the state hospitals from a list of volunteers for that committee, with at least two representatives from the same professional field as the person under consideration for a privilege.

Two of our five hospitals have Bylaws Committees. At both Atascadero and Patton State Hospitals, committee members are appointed by the Chief of Staff from a list of volunteers for that committee. Coalinga State Hospital is newly opened (September 2005) and does not yet have all of the medical staff committees fully functioning.

The following table indicates percentages of psychologists on the medical staff at the time of the BSA Review (discussed earlier), and current percentages of psychologists on the noted committees as of May 2005. Significant progress has been made in increasing psychologist representation on the committees.

## Psychologist Representation on Hospital Committees

Committee	Percentage of Psychologists			Status *
	That Make Up The Medical Staff	July 2004	May 2005	
<b>Medical Executive Committee</b>				
Atascadero	43%	25%	30%	Improved
Metropolitan	22%	22%	10%	Decreased **
Napa	35%	10%	27%	Improved
Patton	32%	14%	18%	Improved
<b>Bylaws Committee</b>				
Atascadero	43%	33%	33%	Not Improved
Metropolitan	22%	n/a	n/a	n/a
Napa	35%	n/a	n/a	n/a
Patton	32%	30%	30%	Meets Goal
<b>Credentials Committee</b>				
Atascadero	43%	43%	50%	Meets Goal
Metropolitan	22%	30%	13%	Decreased **
Napa	35%	20%	25%	Improved
Patton	32%	22%	29%	Meets Goal

\* “Improved” means the percentage of psychologists on the committee is closer to the percentage of psychologists on the medical staff. “Not Improved” means the percentage of psychologists on the committee has not increased. “Decreased” means the percentage of psychologists on the committee is less. “Meets Goal” means the percentage is approximately the percentage of psychologists on the medical staff.

\*\* Between July 2004, and May 2005, changes within the Department of Psychology resulted in temporary vacancies on some committees. The Department Chair passed away and some members of the department retired resulting in a shifting of some department positions.

## **Actions Still to be Taken**

The role of psychologists is continuing to expand, not only by clarifications in the Title 22 regulations, but by increased duties and responsibilities in the implementation of the Recovery Treatment Model (as discussed previously). DMH will also continue to address barriers as they arise, that prevent psychologists from practicing their profession to the fullest extent of their licensure. The attending clinician and clinical leadership issues for psychologists in state hospitals are yet to be fully resolved, but the DMH will continue to work with the DHS to address these issues. A fully integrated medical staff, utilizing all the training, knowledge, expertise, and competencies available is the key to providing quality mental health care.

Under the new Recovery Treatment Model, the psychologists have increased responsibility for performing behavioral assessments, psychometrics, leading positive behavioral support groups, running treatment groups, and providing behavioral consultation. Implementation of the Recovery Treatment Model is expected to improve the quality of patient care by better matching clinical resources with patient needs.

The Recovery Treatment Model with its emphasis on person-centered, fully integrated holistic care provided in the way most advantageous to the individual can best be employed when psychologists are fully integrated into the medical staff. This recognition of the wide-ranging and important contributions psychologists can and do make to further an individual's recovery greatly contribute to the overall quality of care. Individual treatment plans are developed and approved by all members of the treatment team, and are not solely the product of psychologists. Psychologist membership has generally increased the sense of teamwork, understanding, communication, and collaboration between psychologists and the other disciplines of the medical staff.

DMH has identified three areas of focus to further increase the utilization of psychologists;

1. Continued implementation of the Recovery Treatment Model
2. Continued discussions over the attending clinician and clinical leadership issues
3. Continued focus on psychologist representation on medical staff committees

## **Impact of Quality of Care and Cost Effectiveness**

While DMH has not conducted a formal study on the impact of medical staff membership and privileges for clinical psychologists on quality of care and cost effectiveness, we believe the result has been improved quality of care with no additional cost. This conclusion has been reached because:

- The process of including psychologists on the medical staff and seeking clinical privileges requires the definition and assessment of the practitioner's ability to provide and practice quality patient care.
- Medical staff membership and participation requires a level of practitioner peer review that is not required outside the medical staff structure.
- The Governing Body provides an additional level of oversight on the quality of care processes of the Department of Psychology and the medical staff.
- Utilizing the unique training and skills of psychologists, within the Recovery Treatment Model, particularly with individuals who have extreme behavioral problems, enhances quality of patient care. This likely reduces costs at the hospitals by reducing length of stays, assaults, and staff injuries.
- Better utilization of psychologists in the state hospitals has the potential to enable the use of the psychiatric resources more effectively and increase quality of patient care by allowing greater attention to psychiatric assessments, medication management and treatment planning.

## CALIFORNIA DEPARTMENT OF MENTAL HEALTH

### SPECIAL ORDER

Section 000-099 Organizational/Governance

**Special Order No.: 008**

Effective Date: January 2, 2003

Replaces: New

Subject: **CLINICAL PSYCHOLOGIST FUNCTIONS**

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**Special Order:** This order sets forth the functions Clinical Psychologists may perform in state hospitals.

**Authority:** The authority for this special order is based on the general authority given the Department by the Welfare and Institutions Code Sections 4000 and 4100 et seq., and Section 1316.5 of the Health and Safety Code.

**Background:** Patients are committed to state hospitals pursuant to applicable sections of the Penal and Welfare and Institutions Codes. The Medical Director of a state hospital is responsible for the care and treatment of all patients committed to the institution. Typically state hospital patients have multiple medical, psychiatric and behavioral disorders. Because of these complex medical, diagnostic and treatment dynamics the Medical Director delegates the overall responsibility for each patient's care to an attending physician. However, in order to integrate the contributions of the multidisciplinary team, the attending physician is expected to collaborate with the members of the treatment team to establish a comprehensive treatment plan for each patient.

The governing authority and medical staffs of each state hospital are required to limit a medical staff member's practice to only those clinical activities for which the practitioner can demonstrate that he/she meets the applicable criteria for education, experience and current competency. The governing authority and medical staff of each hospital must also consider the hospital's mission and resources and the needs of the patients when granting clinical privileges or making assignments. A clinical license may permit a practitioner to perform a wide range of clinical assessments and interventions that in a state hospital setting are subject to the conditions described above.

**Purpose:** To more effectively utilize the professional knowledge and skills of Clinical Psychologists.

**Method:** The governing authority and each hospital have established policies and procedures for the establishment and granting of clinical privileges and for making administrative clinical assignments. These policies and procedures shall be used to establish and grant clinical privileges and/or make administrative

assignments. An assignment will be dependent on patient and hospital needs and subject to meeting the education, experience and current competency criteria established for the applicable clinical privileges or administrative assignments.

The following functions are presented as administrative assignments designed to aid in the delivery of patient care in state hospitals. These functions may be performed by clinical psychologists when the activities are part of the patient's approved treatment plan or are delegated by the physician responsible for the patient's overall care. It should be noted that some of these assignments may require the psychologist to have been granted the appropriate clinical privileges in order to perform the function.

1. Request non-medical consultations, e.g., educational evaluations, vocational testing, vocational training and industrial assignments
2. Order or provide psychological, educational and neuropsychological assessments and therapy
3. Order or provide psychological assessments and diagnosis.
4. Order or provide
  - Behavioral assessments
  - Behavioral Management Plan development
5. Provide risk assessment
6. Provide crisis intervention
7. Provide post incident debriefing and crisis intervention
8. Provide assessment of suicide risk
9. Develop treatment plans for the consideration of the treatment team and the review and approval of the attending physician
10. Order or provide individual and/or group psychotherapy
11. Order or provide family therapy
12. Order or provide biofeedback (where approved by the hospital)
13. Order or provide hypnotherapy (where approved by the hospital)
14. Develop criteria for release from restraint and seclusion
15. Assess patient's readiness for release from restraint and seclusion
16. Prepare court reports and testify
17. Testify at hearings
18. Conduct pre-admission non-medical screening
19. Plan, implement, evaluate and report on Core/Mall curriculum, and treatment
20. Order grounds privileges, close and constant supervision (1:1, etc), and/or escort ratios
21. Recommend to the Attending Physician and members of the treatment team therapeutic treatment and behavioral interventions
22. Coordinate/monitor the implementation of the treatment plan for assigned patients
23. Educate patients and staff regarding signs, symptoms and treatment of mental illnesses



24. Consult with unit staff and others regarding individual patients, mental illness, treatment approaches, behavioral assessments and behavioral interventions
25. Write treatment orders as delegated by the assigned physician
26. Perform the duties of a Psychologist of the Day (PhD.OD)
27. Function as a treatment team facilitator / coordinator

Using the existing privileging and assignment process, psychologists may perform other duties unique to the needs of the hospital and patients served. Psychologists are expected to meet the applicable education, experience and current competency criteria for these assignments.

An effective treatment team utilizes the expertise of all its members to develop and implement a treatment plan that optimizes patient care. It is expected that all members of the medical staff and the treatment team will work effectively together in a spirit of cooperation and collegiality, to achieve the highest level of patient care possible for patients in the state hospital. Should a difference of opinion occur on the subject of diagnosis, modality, procedure, treatment recommendation, appropriateness of interventions, etc., it is expected that differences will be resolved at the lowest level possible. However when this is not possible or appropriate, existing processes should be used to resolve these differences.

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JOHN RODRIGUEZ, Deputy Director  
Long Term Care Services  
Department of Mental Health

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Date

## CALIFORNIA DEPARTMENT OF MENTAL HEALTH

### SPECIAL ORDER

Section 000-099 Organizational/Governance

**Special Order No.: 009**

Effective Date: September 1, 2004

Replaces: New

Subject: **MEDICAL STAFF COMMITTEE COMPOSITION**

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**Special Order:** This order sets forth the composition of specified committees of the medical staff in state hospitals.

**Authority:** The authority for this special order is based on the general authority given the Department by the Welfare and Institutions Code Sections 4000 and 4100, and Section 1316 et seq. of the Health and Safety Code.

**Background:** As medical staffs change in size and as disciplines are added to the medical staff, the composition of the following administrative committees of the medical staff shall, as appropriate, reflect the membership of the overall medical staff:

- Medical Executive Committee,
- Bylaws Committee, and
- Credentials Committee

**Purpose:** To more effectively utilize the professional knowledge and skills of the various disciplines of the medical staff.

**Method:** Hospitals shall annually review the composition of their medical staffs and the proportion of various disciplines and license types, and to the extent possible modify the membership of the Medical Executive, Credentials and Bylaws Committees to more closely reflect the composition of its medical staff, understanding that the Medical Executive Committee membership is determined by election, not appointment.

The first review shall be completed before October 31, 2004, and shall be conducted at least annually after that. Changes in committee composition shall be completed during the normally scheduled voting for and/or appointment of committee members.

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JOHN RODRIGUEZ, Deputy Director  
Long Term Care Services  
Department of Mental Health

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Date

## CALIFORNIA DEPARTMENT OF MENTAL HEALTH

### SPECIAL ORDER

Section: Clinical Services

**Special Order No.: 129**

Effective Date: September 1, 2005

Replaces: New

Subject: **Positive Behavioral Support**

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**Special Order:** This Special Order outlines the policies and procedures regarding the Positive Behavioral Support program for all Department of Mental Health State Hospitals. Each State Hospital shall incorporate this policy into their Positive Behavioral Support Administrative Directive without interpretation. The state hospital administrative directives shall contain the definitions and procedures that are used within this Special Order.

**Authority:** By order of the Deputy Director Long Term Care Services, and Title 22 regulations.

**Reference:** The PBS philosophy that forms the basis for this AD is contained in: Carr, E.G., Dunlap, G., Horner, R. H., Koegel, R. L., Turnbull, A. P. Sailor, W., Anderson, J.L., Albin, R.W., Koegel, L. K., & Fox, L. (2002). Positive behavior support: Evolution of an applied science. *Journal of Positive Behavior Interventions*, 4, 4-16.

**Purpose:** To provide the state hospitals with uniform direction with the Positive Behavioral Support Program.

### **Method:**

#### **I. Definitions**

- A. **Positive Behavior Support (PBS):** Embedded in the overall Wellness and Recovery Plan (WRP), PBS is a process of collaborative assessment, intervention planning, and implementation of interventions by the individual, the individual's Wellness and Recovery Team (WRT), other caregivers and professional staff, consultants, and family members. PBS plans are designed to support individuals in developing and maintaining recovery-enhancing behaviors and life styles. As positive functionally equivalent "replacement behaviors" develop, maladaptive behaviors are rendered irrelevant, inefficient and unnecessary. PBS is a data-based approach to behavior change that employs empirical evaluation of intervention outcomes. It is fully compatible with and complements other treatment strategies that focus on aspects of the individual's recovery, growth and development as a whole person.

- B. Positive Behavior Support Team (PBS Team): A PBS team consists of a Clinical Psychologist, Registered Nurse, two Psychiatric Technicians and a Data Person. One of the Psychiatric Technicians and the Data Person on a PBS team can be Behavior Specialists. The PBS team is appointed and supervised by the Chief of Psychology in consultation with the Medical Director and Clinical Administrator. The accountability of the PBS team rests with the Chief of Psychology. Each PBS team functions as a unit, under the direct supervision of the psychologist of the team, and all clinical assignments within a team are directed by the team psychologist in consultation with the Chief of Psychology.
1. Each PBS Team is designed to have a caseload of no more than 300 individuals.
  2. All members of the PBS team must receive specialized training and continuing education in the philosophy, development and implementation of PBS plans.
  3. All team members are expected to work flexible hours and provide training to staff on PBS plans, assist with the initial implementation of the plans, and monitor the effectiveness of the plans across all three shifts.
- C. Behavioral Consultation Committee (BCC): The BCC is a clinical consultation committee that provides clinical guidance to an individual's Wellness and Recovery Team (WRT) in assessing, developing and implementing interventions, and monitoring outcomes for individuals with complex psychiatric and psychological issues.
1. Membership includes the Medical Director or designee, Clinical Administrator or designee, Chiefs of Psychiatry and Psychology who are the co-chairs of the BCC, plus the Chiefs of Social Work, Rehabilitation, and Nursing. In addition, Chairs of the Departments/Services of Medicine, Psychiatry, Psychology, Social Work, and Rehabilitation and those individuals appointed to represent relevant areas of expertise, e.g., pharmacy, nutrition, neurology, neuropsychology, nursing, developmental disabilities, and Standards Compliance are standing members of this committee.
  2. All members of the BCC or their designees shall attend as assigned by the Chief of Psychology all appropriate BCC meetings.
  3. In addition to its involvement with select PBS Team consultations as described in section VI, "BBC Responsibilities," subsection A, the BCC may, after review of those cases identified by the hospital's 10

daily triggers in which a Level I and Level II review has occurred, but the individual in question continues to activate one or more of the daily triggers, require the WRT to present the individual to the BCC for consultation.

4. All PBS Team members assigned to a certain individual shall attend BCC meetings.

## **II. Policy**

- A. PBS is guided by several core values including respect for individuals' rights, the importance of the individual and a person-centered approach to support planning, treating people with dignity, and protecting individuals from neglect or abuse (see Carr et al., 2002, cited above).
- B. Each WRT will utilize the values and principles of PBS in planning and developing behavioral and cognitive behavioral treatments for the individuals they serve.
- C. PBS Team services will be available to all individuals on a referral basis in order to help them live more enjoyable, normal and independent lives.
- D. The criteria for referral are described below. Factors that may influence the prioritization of a PBS Team's responses to referrals include the relative urgency of an individual's needs as well as the current active caseload of the PBS Team.
- E. PBS Teams provide specialized consultation services which include the following:
  1. Education and training of staff in the principles of PBS, and the development and implementation of PBS plans.
  2. Consultation with WRTs working with individuals with maladaptive behaviors.
  3. Structural and functional assessment of maladaptive behaviors.
  4. Assistance and support in developing and implementing positive behavioral interventions for individuals.
  5. Together with the unit and mall staff, at least one PBS team member will personally implement each new PBS plan during the first week of the initial implementation of the plan.
  6. Development and implementation of institutional policies and practices related to positive behavioral interventions.

- F. PBS plans include teaching functionally equivalent replacement behaviors as well as other socially desirable behaviors.
- G. PBS plans shall not include the use of punishment or any aversive contingencies.
- H. PBS Teams do not provide interventions specifically for personality disorders, but may assist in the treatment of instrumental target behaviors of individuals with personality disorders. Interventions for personality disorders are determined by the individual's WRT and provided in the mall and/or in individual therapy by professionals trained in treating personality disorders.

### **III PBS REFERRAL PROCEDURES**

- A. The WRT may seek consultation for specific individuals. The consultation requests should be in writing, and must be signed by a representative of the WRT.
- B. There are two (2) types of referrals:
  - 1. Type A: For less complex behavioral issues. With this type, it is the responsibility of the psychologist referred to the unit to complete a behavioral assessment, and develop and monitor a PBS plan for the individual. The PBS Team serves as a consultant offering guidance and recommendations, as requested.
  - 2. Type B: For more complex behavioral issues, especially those that require specialized assessment such as structural or functional assessment, and cases where the unit-generated PBS plan has been ineffective. The PBS team, in collaboration with the WRT, will conduct additional behavioral assessments, including functional analysis as indicated, recommend specific interventions, and teach the unit staff to implement the recommendations.
    - a. The following are examples of individuals who may be appropriate for PBS Type B referrals:
      - 1. Need for frequent use of intrusive interventions, such as PRN medications, or seclusion or restraint to prevent aggressive or self-harm behaviors that have not been resolved through other treatment efforts.
      - 2. Repeated medication refusal.
      - 3. Ongoing failure to meaningfully participate in treatment (e.g., consistently failing to attend treatment).

4. Challenging behaviors related to the presence of dementia or other neuropsychological difficulties.

#### **IV PBS TEAM RESPONSIBILITIES**

- A. The PBS Team will log and record all referrals. Using specific criteria (Refer to PBS Technical Manual), the PBS will prioritize the referral and determine its type.
- B. The PBS Team will respond to a referral within 72 hours with a written acknowledgement, and request a meeting with the WRT. At this meeting, the referral will be discussed and plans for collaborative assessment will be drawn and finalized. In turn, the WRT, in consultation with the PBS Teams, will schedule a second meeting to discuss the results of the collaborative assessments and to draw up and finalize a PBS plan for the individual as soon as possible.
- C. For Type B referrals, a behavioral assessment shall be performed by the PBS Team in collaboration with the WRT. The PBS Team will present the results to the WRT as soon as possible. The PBS Team will develop an initial PBS plan and present it to the WRT for discussion and joint agreement on the final PBS Plan. The PBS Team will develop a single sheet of staff instructions (PBS Guidelines), in clear and simple language, which specify the steps staff are to follow when the individual exhibits target and collateral behaviors.
- D. The PBS Guidelines will be included in the interventions in the individual's WRP and be attached to the WRP.
- E. The extended report developed by the PBS team that includes their clinical methodology, rationale, assessments, and determination of behavioral supports needed by an individual shall be kept by the PBS team as a reference for the PBS Guidelines.
- F. The PBS Team will teach the individual's WRT how to implement the PBS Guidelines. The individual's WRT is responsible for the implementation of the plan.
- G. The PBS Team will assess the fidelity of implementation of the PBS Guidelines, on a monthly basis, either by direct observation or through planned behavior drills. Fidelity data will be included in the hospital's Monthly Monitoring Report.
- H. Each PBS Team will be responsible for the overall monitoring of outcome data on PBS interventions developed by the PBS Team.

- I. The PBS team in collaboration with the unit psychiatrist will integrate PBS plans with other therapies, especially pharmacotherapy.
- J. PBS Teams at each hospital shall be responsible for meeting current professional standards in the development and implementation of PBS plans. The PBS Monitoring Checklist shall be used to assess the quality of each new and revised PBS plan. An external auditor shall provide independent reliability checks on the quality of the PBS plans using the same instrument.
- K. The PBS Team shall provide mandated training in PBS philosophy and methods to hospital employees who work as unit staff or mall providers. The training will be based on the PBS manual and special curriculum developed for this purpose.

**V. WELLNESS & RECOVERY TEAM RESPONSIBILITIES:**

- A. The WRT, in collaboration with the PBS Team, will finalize the PBS Plan. With the agreement of the individual, the unit Social Worker may invite family members/significant others or the conservator to participate in the development of the PBS plan.
- B. After the initial training by the PBS team, the unit or other designated psychologist, in consultation with the PBS Team, will be responsible for providing all follow-up training to clinical staff as needed.
- C. After the initial training by the PBS team, the unit supervisor, in consultation with the PBS Team, will be responsible for providing all follow-up training to the nursing staff as needed. The PBS team will provide follow-up training to mall staff.
- D. The unit and mall staff shall implement the PBS plan and collect data on the target and collateral behaviors as specified in the PBS Plan.
- E. The implementation and the clinical effectiveness of PBS interventions shall be assessed at least every two weeks by the unit psychologist with the assistance of the Unit Supervisor. The data will be shared with the WRT and the PBS Team for review and tracking of progress. Based on outcome data, the unit or other designated psychologist and the PBS team will jointly revise the PBS plan, as necessary.
- F. If the individual's care requires BCC involvement, the WRT will be required to consider and respond to all BCC recommendations. When the WRT elects to address an identified concern via an alternative



approach, the WRT will provide a written clinical rationale at the next scheduled BCC review date.

**VI. BEHAVIOR CONSULTATION COMMITTEE (BCC) RESPONSIBILITIES:**

- A. Individuals with very complex needs who are already involved in a PBS consultation based plan, but who require additional consultation and decisions that are beyond the ordinary scope of the PBS Team will be referred to the Behavior Consultation Committee (BCC). The Chair of the PBS Team shall be responsible for scheduling the BCC meeting. At the BCC, the WRT shall present the details of the individual's assessments, needs, difficulties, and responses to current interventions.
- B. The BCC shall deliberate on the referral questions and make recommendations to the WRT and PBS Team. These recommendations will be followed unless the WRT provides a written, clinical rationale for an alternate way to address the issue.
- C. The minutes of the BCC meeting shall be recorded and maintained by the PBS Chair.
- D. BCC recommendations will be signed by the committee chairs, distributed to the WRT by the PBS team, and included in the individual's chart under consultations.

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Date